DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/26/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION 00			r 1	(X3) DATE SURVEY COMPLETED	
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			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					STATE BLVD		
EMERITI	JS AT FORT WAYN	E		FORT V	VAYNE, IN46815		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECT		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)		COMPLETION DATE
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110000			-				
		r the investigation of	R0000				
	Complaint Numb	per IN00094798.					
	Complaint Numb	nar.					
	_	substantiated due to lack					
	of evidence.						
	Unrelated deficiency is cited.						
	Survey dates: August 29, 30, 2011						
	Facility number: 003273						
	Provider number: 003273						
	AIM number: N/A						
	Survey team:						
	Ann Armey, RN						
	Census Bed Type:						
	Residential: 63						
	Total: 63						
	Census payor type: Other: 63						
	Total: 63						
	Sample: 3						
	This state finding with 410 IAC 16	g is cited in accordance .2-5.					
	Quality review 9/01/11 by Suzanne						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QEBS11

Facility ID:

003273

TITLE

If continuation sheet

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 08/30/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4730 E STATE BLVD **EMERITUS AT FORT WAYNE** FORT WAYNE, IN46815 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Williams, RN R0246 (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. 1. The MARs and charts were R0246 09/16/2011 Based on interview and record reviewed for Residents #B and review, the facility failed to assure #C, no negative outcomes were a QMA received and documented noted.2. MARs and charts of the residents that QMAs are authorization to administer PRN responsible for were reviewed medications. This deficiency from 8/30/2011 through 9/8/2011. Only one PRN medication had affected 2 of 2 residents, who been given, permission was received PRN medications, in a asked and granted, proper documentation was noted.3. sample of 3. (Resident #B and #C) QMAs received a one on one in-service reviewing their scope of practice. An in-service for all Findings include: licensed nurses and QMAs is scheduled for September 15, 1. The clinical record of resident #C 2011 to again review the QMAs scope of practice for giving PRN was reviewed on 8/29/11 at 11:00 medications. During weekly med a.m. and indicated the resident was cart audit we will be reviewing the MARs and Charts of 5 random admitted to the facility on 6/4/11, residents to check PRN with a diagnosis which included but medications administration and documentation, the audits will be was not limited to, Alzheimer's conducted by the Resident Care Disease. Director or Designee.4. The weekly med cart audits will be reviewed by the Executive The August 2011 MAR Director and/or designee weekly

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If continuation sheet

Page 2 of 7

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nurse was in the facility										
twenty-four hours each day, and the										
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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING	COMPLETED 08/30/2011
B. WING	
	ZIP CODE
STREET ADDRESS, CITY, STATE,	, ZII CODE
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QMAs should obtain and document	DAIL
that the licensed nurse authorized	
the use of the PRN medication.	
The clinical record was reviewed	
with the RCD and there was no	
documentation indicating the	
licensed nurse had been consulted	
or authorization had been obtained	
each time the PRN Ativan and	
Tylenol were administered to	
Resident #C by QMA #1.	
2. The clinical record of Resident	
#B was reviewed on 8/29/11 at 2:15	
p.m. and indicated the resident was	
admitted to the facility on 6/19/07	
with a diagnosis which included but	
was not limited to, dementia.	
was not infinted to, deficilitia.	
The August 2011 MAR	
(Medication Administration	
Record) indicated Resident #B had	
a physician's order to give Ativan	
0.5 mg, every six hours as needed	
for anxiety or agitation.	
The Nurses Medication Note	
indicated the Ativan had been given	
by QMA #1 on 8/19/11 at 7:30 p.m.	
There was no documentation the	

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			B. WING		08/30/20	011		
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				1 TO 10		(115)		
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TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE		
	nurse had beer							
	authorization l	nad been obtained						
	when the PRN	Ativan was given to						
	Resident #B.							
	On 8/29/11 at	3:25 p.m., QMA #1						
	was interview	ed. She indicated she						
	thought she ha	d checked with the						
	nurse before g	iving the PRN						
	medications to	Residents #C and						
	#B and she should have							
	documented th							
		was unsure what						
		ause it was very busy						
		ie indicated she						
		service on 8/29/11						
		N medications was						
	on 8/29/11 at 4:30 p.m., the RCD was interviewed. She indicated they had no specific policy regarding QMAs giving PRN medications, and the facility followed Indiana's QMA regulations and guidelines.							
	-							
	The QMA reg	ulations, including						
		Scope of Practice,						
provided by the RCD, were								
	1							

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	reviewed, on 8	3/30/11 at 9:30 a.m.,						
	and indicated t	the following:						
	"(11) Admin	ister previously						
	ordered pro re	nata (PRN)						
	medications or	nly if authorization is						
	obtained from	the facility's licensed						
	nurse on duty	or on call. If						
	authorization i	s obtained, the QMA						
	must do the fo	llowing:						
	(A) Document in the resident record symptoms indicating the							
	need for the m	edication and the						
		toms occurred.						
	` ′	in the resident record						
	that the facility	y's licensed nurse was						
	contacted, sym	•						
		permission was						
	granted to adm							
		cluding the time of						
	contact. (C) Obtain permission to administer the medication each time the symptoms occur in the resident.							
	` '	at the resident's record						
	is cosigned by the licensed nurse							
		nission by the end of						
		ft or, if the nurse was						
		end of the nurse's						
	next tour of duty"							

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	the records an involved and i	ctor was The Executive ated they had checked d only one QMA was in those cases; the						